STATE OF GEORGIA
OLMSTEAD STRATEGIC PLAN
GOVERNOR SONNY PERDUE

Principle

The State of Georgia is committed to advancing the principle that people with disabilities and the aging population are served in the most appropriate, integrated settings. This document outlines what has been done in Georgia and the strategies for continued improvements in the service delivery system. The State's response will be guided by the principle of partnership between the state agencies and individuals, their families and their communities to bring the resources of each partner together to provide the services to individuals in community settings.

Background

The United States Supreme Court issued the *Olmstead v. L.C.* decision on June 22, 1999 holding that unnecessary segregation of individuals in institutions may constitute discrimination based on disability. The *Olmstead v. L.C.* case involved two Georgia citizens with disabilities residing in a state institution, and it held that "undue institutionalization qualifies as discrimination" under the Americans with Disabilities Act (ADA). It also recognized the States' need to maintain a range of facilities for the care and treatment of persons with diverse disabilities, and thus the need to consider the resources available for providing a range of services in addition to services in the community. The decision suggested that a state could establish compliance with ADA if it demonstrated that it has a comprehensive, effectively working plan for placing eligible persons with disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace given the resources available and not controlled by trying to keep the State's institutions fully populated.

In December 1999 a Blue Ribbon Task Force on Home and Community-Based Services convened, recognizing

> *. . . that the provision of health and human services has changed in recent years and that the concept of institutionalized care has been evolving toward a philosophy of providing community-based services and programs designed to prevent early and unnecessary institutionalization and to allow persons with widely varying needs, such as children, the elderly, people with mental illness or impairment, people with developmental disabilities and people with physical disabilities, to receive the support necessary to live independent and productive lives in the community.*

The Blue Ribbon Task Force (consumers, family members, advocates and professionals with a broad range of knowledge and experience) met over several months and presented a final report in January 2001 that provided recommendations on the following:

- The future need for community-based services;
- The barriers that prevent access to existing community-based services;
- General funding recommendations based on current actual funding and limited new funding; and
- Prioritization of services and possible criteria for waiting lists if funding is fixed or limited.

In April 2000, the Department of Human Resources (DHR), as the lead state agency, applied for and carried out the activities of a grant from the Center for Health Care Strategies. Upon receipt of the grant, Georgia established the Olmstead Planning Committee. This committee included consumers of services, members of consumers' families, advocates, providers of services to persons with disabilities, and leaders of the Department of Community Health (Medicaid) and DHR (MHDDAD, Aging, DFCS, ORS). The Olmstead Planning Committee and its various workgroups met between February and October of 2001. This Committee incorporated, and built upon, the work of the Blue Ribbon Task Force. The Olmstead Planning Committee finalized its report and recommendations in November 2001, and representatives of the Committee presented the final report to the DHR Commissioner and DCH Commissioner on January 30, 2002.

The State's continued compliance with the ADA is evolutionary in nature and will be refined as implementation proceeds. The needs and desires of people with disabilities and the aging population continue to change, as do the resources and supports to assist them. This strategic plan emphasizes the following goals and philosophies to which the State aspires:

> *Person-Centered Planning and Care Management* – Person-centered planning and care management calls for the consumer to be the primary focus and the consumer, along with family and significant others, as appropriate, is an active participant in planning, delivery and evaluation of services. In addition, this means that when a team approach is used, the team also should be "person-centered."
>
> *Consistency of Services* – Consistency of services means that the service systems are designed to ensure that consumers can rely on services being provided as agreed to by the consumer and the program representative. This means that the services are timely, consistent, dependable and appropriate.

Available and Accessible Services – Access to services is maximized when they are developed to meet the needs of the consumer. Service provider restrictions, limitations or assignment criteria are clearly identified to the consumer, family and significant others, as appropriate.

Most Integrated Setting Appropriate to Individual Needs – Consumers should be assessed for the most integrated setting appropriate to their individual needs. In that process, consumers are afforded informed choice about service options appropriate to their service needs.

Collaboration with Stakeholders – The appropriate mix of services will continue to change. Resources should be aligned with identified consumer needs and preferences. Efforts are made to include consumers, families and other significant persons, service providers and related community resources, to assess and review the change of the service spectrum. Changes to the service system are planned, implemented and evaluated for continuous quality improvement.

Equitable Allocation of Resources – Because the State is required to provide for the care and treatment of a large and diverse population of persons with disabilities, available resources will be allocated in as equitable a manner as possible, taking into account the needs of consumers already being served and those waiting for services.

The State will look at system improvements, including needed infrastructure changes and development, so that it can continue to strive for assurance that persons with disabilities have appropriate access to and choice regarding community-based services and placements. With the cooperation of consumers, family members, advocates, providers and applicable state and local agencies, the State of Georgia strives to move forward in the provision of appropriate services and supports for all eligible Georgians.

The State's provision of community placements and services can take place only within the limits of State funds specifically appropriated therefore. Thus, the State aspires to transition individuals to appropriate community-based service programs to the extent practicable given its available resources. The State makes reasonable modifications in State policies, practices and procedures, without fundamentally altering the nature of the services, programs and activities.

Goals of the Plan

The goals of the plan are to:

1. Create a practical structure for implementation of a plan, which draws on the advice of the Olmstead Planning Committee report.

2. Identify areas for improvement in the delivery of community-integrated services and supports for people with disabilities and the aging population.

3. Ensure that consumers, family members and other stakeholders are involved in the ongoing process for improving community-integrated services.

4. Establish sustainable, State processes for identification, assessment and planning for qualified individuals.

5. Continue the process for annual budget planning to support agency operational plans related to the Olmstead Working Plan.

6. Set the strategic direction for state agency operational strategies to address the plan.

Georgia's Citizens Affected by the Olmstead Plan

Citizens of Georgia affected by the plan include qualified individuals with a disability who meet the criteria established under the ADA, if:

- The individuals have the treating professionals' recommendation for less restrictive placement;

- The individuals do not oppose the recommended placement; and

- The State does not have to make fundamental alterations of its services and programs that impact other persons in need of service.

This plan specifies the principles that will be used for assessment and identification of qualified individuals with disabilities and for ensuring that they can make informed choices. These groups of people with disabilities may include the following:

- Children and Adults with Serious Mental Illness/Serious Emotional Disturbance
- Children and Adults with Mental Retardation/Developmental Disabilities
- Children and Adults with Physical Disabilities/Motor Impairments (Hearing Impaired/Visually Impaired/Spina Bifida, etc.)
- Older Adults with Functional Limitations and/or Disabilities
- Adults with Traumatic Brain Injury

The groups identified above currently reside in the following locations:

- State-operated Psychiatric Hospitals
- State-operated ICF/MR and SNF/MR Institutions/Units
- Nursing Homes
- Private ICF/MR
- Acute Care Hospitals
- Home/Community (those who are at risk for institutionalization)

The long-term services and supports for Georgians with disabilities that meet the above criteria are the responsibility of multiple state agencies. The ongoing collaboration of these agencies is necessary to further Georgia's efforts to meet the long-term needs of this population. Thus, state agencies, under the Governor's direction, will need to ensure the necessary partnerships and coordination to achieve the goals of the plan.

Georgia's Achievements to Date

In recent years, both before and after the *Olmstead* decision, the State supported a number of initiatives to make it possible for individuals with disabilities and older adults to move out of institutions into a range of community-based services or, for those at risk of needing institutional care, to receive community services that would prevent or delay their need for state hospital or nursing home services. Attachment A highlights these prior efforts by the State in the following areas:

- Redirecting resources from hospital to community services
- Closing state hospitals
- Increasing the availability of community-based services
- Addressing the waiting lists for community-based services
- Increasing length of stay in community services and thus delaying the need for institutional care
- Implementing the Medicaid Rehabilitation Option to increase flexibility of community services for people with mental illness
- Expanding the network of crisis and other community-based services for children and adolescents with serious emotional disturbance

In addition to the efforts described in Attachment A, Georgia achieved the following:

Blue Ribbon Task Force on Community-Based Services – The task force studied the critical issues around serving people with disabilities and the aging population in community-based alternatives to institutional care. The task force's recommendations formed the basis of a number of planning efforts to improve community services.

Moving adults ages 21 to 64 from nursing homes – Thirty-eight percent of people ages 21 to 64 residing in nursing homes and identified in recent surveys as potentially eligible for community placement have already been discharged.

Moving adults with serious mental illness from state hospitals – Eighteen individuals with serious mental illness were transitioned from long-term care in a state hospital to the community.

Easier access to information and services – Georgia has implemented an information system called "Gateway" to provide accurate information to older citizens, their families and caregivers on available resources and provide streamlined access to home and community-based services. Front-line staff who are located in the 12 Area Agencies on Aging use an electronic data system to provide information on long-term care options and referral to local providers. These staff are usually the first contact for older Georgians and their families and have been certified through a national program.

Standardized screening and assessment – When an individual is requesting services through the aging network, a uniform system for assessing an individual's level of functioning and services required to stay in the community has been adopted based on this determination of need. An objective set of service delivery options can be made for each individual. The statewide information system is used in planning the best use of available resources. This Georgia data information system, Gateway, was the highlight of a Home and Community-Based Waiver Program training sponsored by the Centers for Medicare and Medicaid Services.

Improved information prior to selection of long-term care options -- The State developed an easy to read booklet containing detailed information about Home and Community-Based Services, noting the various services available through the Medicaid program as alternatives to nursing home care. To date, over 137,487 booklets have been distributed across the state to hospitals, nursing homes, community provider sites, and a variety of other locations.

New family support and natural supports initiatives – These initiatives provide the supports a family or other caretaker needs to continue caring for an individual with mental retardation, autism or other developmental disability. Supports may include respite care, special equipment or intensive direct services. The Governor's Council on Developmental Disabilities is working with the DHR to develop a statewide network of family support services.

Expanding capacity to serve people in the community – Georgia has begun statewide initiatives to improve community services, especially for those with the most severe disabilities or behavior problems:

- Development of state-operated services for those with most severe disabilities or behavior problems; and

- Development of standards for residential services for those with the most complex medical needs.

Nationally recognized peer support services – Georgia is recognized nationally for development and implementation of peer support centers, with certified Peer Specialists on staff, as an essential component of Medicaid Rehabilitation Option services. By providing training and support through successful role models, this service promotes recovery among participants and provides meaningful employment for the Peer Specialists.

Case mix rates for nursing home services – A change in Medicaid rates for nursing home services means higher rates will be paid for serving individuals with the most complex needs. This is expected to be an incentive for serving only individuals with the most severe disabilities in nursing homes.

Increase in provider reimbursement rates – Reimbursement increased by 14 percent to providers of services under the CCSP. Reimbursement to service providers for community mental retardation services increased by four percent.

Improving safety and quality in community services -- Improved quality assurance, monitoring and a standardized evaluation process were developed for more consistency in decisions about individuals' ability to live in the community.

Systems Change Grants – Georgia has received three grants from the federal Centers for Medicare and Medicaid Services (CMS) to overcome barriers to community living for individuals with disabilities and the aging population. Two grants focus on the transition of people from nursing homes to community placements. Projects in the third grant include housing and workforce development, enhancing peer support to help people transition from institutions to community services, and improving communications to consumers and their families and across agencies.

Action Plan

The Action Plan sets the strategic direction and broad parameters for addressing community-integrated service delivery. Any planned action to provide community placements and services can take place only within the limits of State funds specifically appropriated therefore. Thus, the Action Plan emphasizes the State's aspiration to transition individuals to appropriate community-based service programs to the extent practicable given its available resources.

State Planning and Oversight

Actions to address community-integrated service delivery require state planning and oversight.

Goal: The advice of individuals with disabilities, older adults, family members and stakeholders is included in the Olmstead Working Plan development and implementation process.

Action: The State will establish an ongoing process for plan development and implementation that strives for inclusion of people with disabilities and older adults, their advocates and other stakeholders.

Goal: Coordination and collaboration occur across state agencies for a comprehensive, effectively working plan.

Action: The Governor directs state agencies to engage in an ongoing process of refining and updating the plan to overcome barriers to community living. The ongoing collaboration of these agencies is necessary to further Georgia's efforts to meet the long-term needs of this population.

Goal: Effective leadership takes place by identifying State level oversight of Olmstead Working Plan implementation.

Action: The Governor designates the Office of Planning and Budget to provide State level implementation oversight.

Identification and Assessment of Eligible Individuals

Currently, there is not a uniform state process for identification and assessment of eligible individuals. To remedy this problem, it is necessary to have a standardized process for defining the services and supports a person needs to live successfully in a community-integrated setting.

Goal: Steps are taken to prevent or correct current and future premature or inappropriate institutionalization of individuals with disabilities and older adults.

Action 1: Individuals in state hospitals potentially affected by the plan will be identified and then evaluated for their ability to benefit from community services.

Action 2: Individuals in nursing homes potentially affected by the plan will be identified and then evaluated for their ability to benefit from community services.

Action 3: Individuals at risk for institutionalization who have been identified will be evaluated for their ability to benefit from community services.

Action 4: In recognition of the changing needs of individuals over time and new admissions to institutions, identification and assessment of potentially eligible individuals should occur periodically.

Assurance of Individual Choice

Individuals affected by the plan should have the opportunity to make informed choices regarding how their needs can best be met in community and institutional settings. The State needs to improve the process of providing information to individuals with disabilities and older adults so they have the opportunity to make informed choices.

Goal: Individuals with disabilities and older adults are provided with the information necessary to make informed choices.

Action 1: The State, subject to the availability of funds, will develop the capacity to go into nursing homes to meet with individuals for whom community placement has been recommended. Discussions should focus on available community options and whether or not the individuals are opposed to a community placement.

Action 2: The State, subject to the availability of funds, will develop the capacity to meet with individuals in state hospitals for whom community placement has been recommended. Discussions should focus on available community options and whether or not the individuals are opposed to a community placement.

Action 3: The State will establish processes that allow the individual to make his or her own decision about community placement, unless the individual has been found legally incompetent. In such instances, legal guardians will make the decision. When the individual cannot communicate his or her decision but has not been found legally incompetent, input from the individual's family should be considered in the decision-making.

Action 4: The State will continue its processes for assuring informed choice for individuals at risk of institutionalization.

Action 5: The State may develop and maintain an inventory of available community resources and the means to inform and educate affected individuals of those options, and the referral processes. The State may periodically update this inventory.

Operation of Waiting Lists

Georgia has a growing population of individuals with disabilities and older adults. The demand for services continues to exceed available resources, and Georgia will be challenged to move individuals from growing waiting lists at a reasonable pace. Georgia will likely continue to have waiting lists for the foreseeable future. It is therefore necessary for the State to have an equitable approach to the management of waiting lists.

Goal: The State will continue to act in a timely and effective manner in response to the findings of any assessment of affected individuals with disabilities and older adults.

Action 1: Following the comprehensive evaluation, planning, and recommendation for less restrictive placement, and in the absence of an individual's opposition to community

placement, the individual should receive services as specified in the assessment report or be placed on a waiting list for those services.

Action 2: Once there is a determination that an individual at risk for institutionalization will benefit from community-integrated services, the individual should receive services as specified in the assessment or be placed on a waiting list if the services are currently unavailable.

Action 3: A process should be established for prioritizing need on waiting lists for individuals in institutions and those at risk for institutionalization. Periodic reevaluation of need may occur for individuals on waiting lists.

Individual Plan Development and Implementation

When appropriate community-integrated services are available and the individual is ready to be moved from a waiting list, the State will work with the individual, his or her family or representative, and treatment professionals in developing an individualized plan. The person's needs, choices and preferences will underlie the development of each individual's plan. The development of the individualized plan will be driven by what is appropriate and necessary to support an individual in the community, as well as a consideration of any potential legal restrictions and limits, while maintaining a fair distribution of limited State resources. To facilitate transition from an institution to the community, planning needs to begin prior to the transition, continue after placement, and include the development of an adequate support system. The State should encourage a consistent process for the inclusion of affected individuals with disabilities, older adults and their families or representatives in plan development and follow-up.

Goal: Individuals with disabilities, older adults and their families or representatives are included as integral participants in individual plan development and implementation.

Action 1: Transition planning should be tailored to the needs of the affected individual to maximize opportunity for successful community integration, given currently available resources.

Action 2: All support systems should be identified to ensure that individualized plans are comprehensive and work effectively.

Action 3: Partnership between families and state agencies should identify their respective roles in providing services and supports to enable the family member to live successfully in the community.

Action 4: When community-integrated services are available for an individual on a waiting list, an individualized plan will be developed using person-centered planning values and principles. This planning should address all areas of an individual's life, including health, human services, functional abilities, friendships, community involvement, and family relations, in a collaborative process based on the individual's own preferences and values to the extent practicable given available resources.

Current Availability of Community-Integrated Services

Two previous planning efforts identified the availability of community-integrated services, the gaps in these services, and the needed improvements to the service system in Georgia. The planning efforts were:

- Governor's Blue Ribbon Task Force on Home and Community-Based Services
- Olmstead Planning Committee

Final reports of these planning efforts included much detail on the current availability of community-integrated services in Georgia. The following is a brief overview of the current community-integrated services in the state.

Georgia currently has several Home and Community-Based Waiver programs. Although different Medicaid waiver programs include different services, they have some services in common. Each program offers several "core" services such as: service coordination; personal support (assistance with daily living activities); home health services (nursing and occupational, physical and speech therapy); emergency response systems and respite care (caregiver relief). Additional services are available under each program. In addition, other federal and state funding supports community-integrated service programs. These programs include:

Community Care Services Program (CCSP): This program provides home and community-based services to people who are functionally impaired or disabled. The program helps eligible recipients remain in their own homes, the homes of caregivers, or in other community settings as long as possible.

Independent Care Waiver Program (ICWP): This program offers services that help a limited number of adult Medicaid recipients with physical disabilities live in their own homes or in the community instead of a hospital or nursing home. ICWP services also are available for persons with traumatic brain injuries.

Community Habilitation and Support Services Program (CHSS): This program is a Home and Community-Based Waiver for people with mental retardation that was developed as part of the closure of an Intermediate Care Facility for the Mentally Retarded (ICF/MR) in Atlanta. The program serves individuals who have transitioned from institutions, as well as people who were on community waiting lists.

Mental Retardation Waiver Program (MRWP): This program is a Home and Community-Based Waiver for people who have been diagnosed with mental retardation or other developmental disabilities, such as autism, cerebral palsy or epilepsy, that require services similar to those required by people with mental retardation and require the level of care provided in an Intermediate Care Facility for the Mentally Retarded.

ShepherdCare Demonstration: ShepherdCare provides primary care through an outreach program managed by advanced practice nurses who coordinate medical care for individuals with disabilities through the Shepherd Center in Atlanta.

Model Waiver: Model waiver services include private duty nursing and medical day care for individuals under age 21 who are respirator or oxygen dependent.

Service Options Using Resources in a Community Environment (SOURCE): In limited areas of the state, an intensive service coordination demonstration project links primary care with an array of long-term health services in a person's home or community to lessen the need for or eliminate preventable hospital and nursing home care. The SOURCE project serves older adults and individuals with disabilities who are eligible for Medicaid and SSI disability coverage.

Non-Medicaid Home and Community-Based Services for People with Developmental Disabilities: This program provides family support/respite services, room and board, day habilitation services and specialized employment services for people with developmental disabilities. State and federal Social Services Block Grant funds support this program.

Adult Mental Health Community Treatment Services: This program serves adults 18 years of age and older with serious mental illness and have experienced a severely reduced level of functioning. The Medicaid Rehabilitation Option, federal Mental Health Block Grant and state funding support this program.

Child and Adolescent Community Mental Health Treatment Services: This program serves children and adolescents through 17 years of age who have a serious emotional disturbance. The Medicaid Rehabilitation Option, federal Mental Health Block Grant and state funding support this program.

Non-Medicaid Home and Community-Based Services for Elderly People (HCBS): This state funded program provides funds for senior centers, home delivered meals, homemaker services, respite care services, transportation and adult day care.

Goal: The availability of community-integrated services is enhanced.

Action 1: The State should have ongoing review of the availability and adequacy of community-integrated services for individuals with disabilities and older adults.

Action 2: The State should have ongoing review of all funding sources, including Medicaid, to increase the availability of community-integrated services.

Action 3: The State should implement an ongoing process of effective communication and collaboration regarding current community-integrated services and initiatives among agencies and other stakeholders.

Education/Outreach

For Georgians of any age with disabilities finding appropriate services to meet their needs can be a confusing and frustrating experience. While many low-income persons in Georgia qualify for publicly funded services, they may be unaware of the State's programs, the eligibility requirements, or the application process. Knowing where to turn for information and help has become a major concern for many individuals with disabilities, older adults and their families.

Goal: Education and outreach systems inform individuals with disabilities, older adults and their families about how to access and receive publicly funded services.

Action: The State should continually enhance the education and outreach processes that inform individuals with disabilities, older adults and their families about how to access and receive available services. Such processes should be sensitive to cultural and individual differences.

Planned Transitions, Service Expansions and Special Initiatives

The State should address the needs of individuals affected by this plan. State planning should cover both individuals currently residing in institutions as well as those at risk of institutionalization. This planning must take into account the resources available to Georgia and the needs of others who are receiving publicly supported disability services. The State of Georgia develops annual budgets that are influenced by fluctuations in the economy, unforeseen disasters, changes in state and federal laws and regulations, and the priorities of the citizens of Georgia, among many other considerations.

Goal: The movement of individuals affected by the plan into community-integrated services is demonstrated.

Action 1: Attachments A & B provides the State's commitment for Fiscal Year 2003, the Governor's proposals for the amended Fiscal Year 2003 and the Fiscal Year 2004 budgets, and certain other processes for determining future needs to implement the plan.

Action 2: The Governor's Fiscal Year 2004 Budget Report on page 194 proposes developing a demonstration project in a selected DHR service delivery region that would pool all developmental disability related fiscal resources within one budget unit in order to promote flexibility in the delivery of developmental disability services regardless of consumer setting.

Action 3: In future fiscal years, the Governor's Office of Planning and Budget (OPB) will coordinate state agency budgetary requests related to the plan. Each agency will submit an annual budget request for its continued implementation of the plan. The Governor and the General Assembly will consider the available resources and make the final determination of the level of annual budgetary commitment to the plan.

Infrastructure and System Capacity

The Olmstead Working Plan will require improvements in infrastructure and system capacity. State agencies will need to develop the needed infrastructure for expansion of community-integrated services. Improvements will be needed in several areas. These areas and State level actions for them are outlined below.

Service Provider Capacity

The service provider capacity in Georgia should be strengthened in order to meet the needs of the growing population of individuals with disabilities and older adults. The State's ability to transition individuals to community-integrated services is dependent upon a sufficient service provider capacity. Expansion of the current service provider capacity in Georgia will require an increase in the numbers, types and quality of providers.

Goal: A sufficient service provider capacity is developed to meet the needs of affected individuals with disabilities and older adults.

Action 1: The State should develop a plan and strategies to expand the capacity and quality of current service providers and attract new service providers to the system.

Action 2: The State should continue to take steps to modify the Home and Community-Based Waiver Programs to include options, and infrastructure, for consumer self-directed care which will contribute to enlarging the provider capacity, to the extent permissible by applicable laws and regulations.

Action 3: State planning for provider capacity should include encouraging existing institutional providers to transition to providing community services.

Service Expansion

The Georgia service delivery system should be responsive to the individual preferences and demand for choice of services and supports and should expand the available service mix. The transition of affected individuals from institutional to community settings calls for capacity development of new and different quality services. Without additional funding, alternative community services will not grow and be sustained at the rate desired.

Goal: The availability of services and supports is developed to allow affected individuals to live in the least restrictive setting appropriate to their particular needs.

Action 1: The State should analyze current and anticipated future service needs, and develop a detailed strategy to address those needs.

Action 2: The State should increase the coordination of the variety of services and programs needed to meet the multiple needs of individuals with disabilities and older adults.

Action 3: The State should identify regulatory and policy obstacles to service expansion and take steps to modify regulations and policies as appropriate to support community living.

Action 4: The State should include in its plan, steps to maximize existing family and agency resources and identify opportunities for additional funding for service expansion.

Action 5: The State should encourage the development of public/private/family partnerships to support service expansion.

Workforce Development

Georgia, like the rest of the nation, is experiencing labor shortages of health care professionals and related community services workers that support the long-term care and community-integrated service delivery system. Workforce shortage is a complex issue that will take creativity from many different fronts at the federal, state and local levels. The collaboration of multiple partners, including education, business, providers, affected individuals and families, is essential to the State's ability to address workforce shortage issues.

Goal: A stable and well-trained workforce serving individuals with disabilities and older adults is available.

Action 1: The State should make relevant workforce shortage issues a high priority in state agencies' required strategic planning on workforce development.

Action 2: The State should take steps to ensure collaboration and cooperation among state agencies in the development and implementation of retention, recruitment, training and other strategies to ensure a stable and well-trained workforce.

Action 3: The State should encourage public/private partnerships to address workforce shortage issues.

Action 4: The State should develop a medication administration certification program for MHDDAD community provider.

Action 5: The State should implement an initiative to improve direct care staff development through the Real Choice Systems Change Grant.

Housing

Affordable and accessible housing is essential to the transition of individuals from institutions to community-based settings. Individuals with disabilities, including some currently living in institutions, can live successfully in the community. To succeed, they need decent, safe, affordable and accessible housing that is separate from, but provides access to, the community-based supports and services they want and need to live as independently as possible. Nationally, there is a critical shortage of affordable housing. Similarly, Georgia does not have enough affordable housing. Home and Community-Based Waiver Programs and the Medicaid Rehabilitation Option do not pay for room and board. Funding for implementation of modifications and subsidized rental and home ownership programs is insufficient. The use of some subsidies to support home ownership has only recently become a possibility.

Goal: Residential capacity and housing options for individuals with disabilities and older adults are increased.

Action 1: The State should take steps to promote change in housing policies and model more effective strategies for using governmental housing programs.

Action 2: The State should call upon state agencies to partner in the development and implementation of strategies to address the housing needs of individuals with disabilities and older adults.

Action 3: The State should encourage public/private/family partnerships to address the housing needs of individuals with disabilities and older adults.

Transportation

Adequate transportation is vital to successful community integration of individuals with disabilities and older adults. To be a part of the community, individuals with disabilities and older adults need to be able to participate in the activities of general community, such as recreation, employment, worship and shopping, and to access needed services and supports. Georgia has transportation programs designed to meet specific needs, such as the access to medical services by Medicaid eligible individuals and transport to some specific state funded programs in most counties. Public transportation is available in some areas of the State, but not all. Even when public transportation is available, it is designed to serve the general public rather than the unique needs of individuals with disabilities and older adults.

Goal: Adequate transportation systems to support successful community integration of individuals with disabilities and older adults are available.

Action 1: The State should review and modify where reasonable, policies and practices that are counter to taking full advantage of all transportation resources.

Action 2: The State should call upon state agencies to partner in the development and implementation of strategies to address the transportation needs of individuals with disabilities and older adults.

Assistive Technology

Assistive technology can help individuals with disabilities and older adults to conduct activities of daily living, such as communication. Examples of assistive technology include computerized talking boards, scanning communicators, speech amplifiers, and electronic telephone systems, such as Personal Emergency Response Systems. The State should take advantage of available technology which can allow individuals to increase their independence and reduce reliance on paid staff.

Goal: Assistive technology is available to individuals with disabilities and older adults that can benefit from the technology.

Action 1: The State should require that the need for assistive technology be included in assessment and planning for individuals with disabilities and older adults.

Action 2: The State should fully assess how to maximize existing resources and identify opportunities for additional funding for assistive technology.

Transition Planning and Start-up

Adequate transition planning is essential to the successful movement of individuals from institutional to community settings. Medicaid regulations related to the Home and Community-Based Waiver Programs permit the reimbursement of case management/transition planning costs for up to 180 days prior to discharge. To the extent that federal funding is available, states may secure federal matching funds under these waivers for one time, set-up expenses, such as security deposits, that do not constitute payment for housing rent, for individuals who make the transition from institutional to community settings. The State should consider modifying its Home and Community-Based Waiver Programs to incorporate all opportunities to use these waivers to support needed transitions.

Goal: Successful transition of eligible individuals with disabilities and older adults from institutional to community settings occurs.

Action 1: The State should seek funding to support start-up costs through modification of its existing Home and Community-Based Waiver Programs.

Action 2: The State should take steps to find opportunities for funding and partnerships that support transitional planning and start-up costs not covered through the modification of its Home and Community-Based Waiver Programs.

Coordination/Partnerships

This plan requires increased coordination and partnerships among federal, state and local agencies, faith-based organizations, non-profit organizations, other public and private entities, and families. The State already has efforts underway to coordinate planning and resources to enhance the community-integrated service delivery system. Additional opportunities for beneficial coordination and partnerships need to be identified.

Goal: Resources for implementation of the plan are maximized through fostering coordination and partnerships.

Action: The State should identify and where possible, take advantage of opportunities for beneficial coordination and partnerships needed for implementation of its plan.

Monitoring/Oversight Capacity

The expansion of the service delivery system requires increased monitoring and oversight capacity to ensure the health and safety of individuals placed in the community and the quality of the services they are receiving. Additional capacity is needed in the areas of licensure and certification of providers, ongoing monitoring and oversight of service delivery, and technical assistance to providers. As new services are developed to meet the multiple and complex needs of individuals with disabilities and older adults, the State needs to review standards and policies and revise them as needed.

Goal: The State's monitoring and oversight capacities are increased and service delivery guidelines are established as services expand to address the plan.

Action 1: The State should take steps to ensure adequate monitoring and oversight capacity to meet the increased demand.

Action 2: The State should evaluate the need to establish practice guidelines to enhance service coordination as a means to delay or prevent institutionalization.

Increased Technology

The success of this plan requires the incorporation of information technology into all planning, implementation and evaluation processes. Information technology enables the State to increase both efficiency and effectiveness in consumer tracking, outcomes at both the individual and system levels, program compliance, utilization management, and data analysis for planning and decision making. Comprehensive and coordinated information technology systems are essential to the State's ability to evaluate its effectiveness in identification, assessment planning, and transition of affected individuals.

Issue: The State should take full advantage of information technology in the implementation of actions to address the plan.

Action: The State should review the capacity of existing agency information technology systems to support implementation of the plan and develop a strategy for making needed improvements.

State Agency Capacity

The Olmstead Working Plan calls for state agencies to not only increase their current capacity but to develop different types of capacity. Areas in which the State needs increased or new capacity are identification, screening and eligibility determination of affected individuals, person-centered planning, administration and data analysis for planning, evaluation of progress and decision-making. In particular, the State requires additional capacity to provide face-to-face screening of individuals identified as potentially eligible for community placement. It is anticipated that this screening will include determining the potential service delivery model, the individual's desire, and the appropriate referral to needed services.

Goal: State agencies' capacities are expanded as needed to implement the plan.

Action: The State should identify the capacity required in its agencies to implement the plan and take steps to address the needed capacity, to the extent that State resources allow.

Data Management and Evaluation

Ongoing monitoring and evaluation of the system and the care provided to specific individuals is critical to the success of this plan. The State needs a comprehensive, consistent approach to ongoing monitoring and oversight, both at the systems level and the individual level. Data management and evaluation of the State's service delivery system are to be guided by continuous quality improvement principles in its incorporation of feedback on the ongoing implementation of the plan. Georgia strives to have quality characterize its service delivery system and to be a part of the design of each aspect of the system.

Goal: Steps are taken to promote quality assurance, quality improvement and sound management to support implementation of the plan.

Action 1: The State should continually review policies and standards related to the management and accountability of the service delivery system and seek modification to align with implementation of the plan without fundamentally altering the programs carried out by the various agencies.

Action 2: The State should establish quality assurance/improvement systems that involve individuals with disabilities and older adults.

Action 3: The State should develop the capacity for continuous quality improvement of its publicly funded service delivery system.

Budget Planning

Implementation of the plan will require not only a significant amount of resources from the State of Georgia, but will require a high level of inter-agency coordination. The Governor's Office of Planning and Budget will work with the affected departments to support the development of appropriate policy and fiscal processes to assist with the placement of persons in the most appropriate setting. These processes include:

- Coordinating agency budgetary requests related to the plan, taking into account the cost of providing services to individuals in the most appropriate integrated setting, the resources available to the state, and how the provision of services affects the ability of the state to meet the needs of others with disabilities.

- Coordinating with agencies to evaluate the feasibility, mechanisms and processes for having funding follow the consumer.

- Working with agencies to identify issues and regulatory or administrative changes necessary for the implementation of the plan.

- Working with agencies to develop specific budget requests for the transition of individuals from institutions to the community, in addition to the appropriate placement of individuals at risk of institutionalization.

Conclusion

Governor Perdue and the State of Georgia commit to moving its agencies and services toward actions in support of community-based services for people with disabilities and older adults. The State welcomes the opportunity to continue its work with consumers, family members, advocates, providers and agencies to improve the systems of services and supports for affected individuals with disabilities and older adults.